Ozaukee County Public Health Department

Immunization Questionnaire

Name of person to be immunized: _____ **DOB:** _____

Please answer these questions about the person to be immunized:

1. Who is to be given immunizations: □ Adult (18 or older) or □ child
2. If this person is a child, are you this child's parent or guardian? ..... □ Yes □ No
3. Have you read the vaccine information sheets about the immunizations requested and read/received the privacy information sheet? ..... □ Yes □ No
4. Has this person had chickenpox? ..... □ Yes □ No
   If no: Has this person received varicella vaccine? ..... □ Yes □ No Year of Illness
   Are you requesting varicella vaccine to be given today? ..... □ Yes □ No _____
   Do you want more information about varicella vaccine? ..... □ Yes □ No
5. Is this person sick today? ..... □ Yes □ No
6. If this person is an infant, is the infant's mother known to be hepatitis B positive? ..... □ Yes □ No
7. Does this person have serious, life-threatening allergies to medications, food, latex or any vaccine? Explain: _____ .... □ Yes □ No
8. Has this person had a serious reaction to a vaccine in the past? ..... □ Yes □ No
9. Has this person had a seizure or a brain problem? ..... □ Yes □ No
10. Does this person, or any person who lives with or takes care of this person have cancer, leukemia, AIDS, bone marrow transplant or any other immune system problem? ..... □ Yes □ No
11. Has this person, or any person who lives with or takes care of this person, taken cortisone, prednisone, other steroids, anticancer drugs, or x-ray radiation treatments, in the past 3 months? ..... □ Yes □ No
12. Has this person received a transfusion of blood or plasma, or been given a medicine called immune globulin or gamma globulin in the past year? ..... □ Yes □ No
13. Is this person pregnant or is there a chance this person could become pregnant in the next 3 months? **Some vaccines may cause serious problems for an unborn baby.** ..... □ Yes □ No
14. Has this person fainted or been light-headed when getting a shot or blood test? ..... □ Yes □ No
15. Has this person received any vaccines or antiviral medications in the last four weeks or are you planning on having any vaccinations? ..... □ Yes □ No

Did you bring this person's immunization record with you today?

It is important for you to have a personal record of your shots (or your child's shots). If you don't have a record/card, ask the nurse to give you one! Bring this record with you every time you come to the clinic. Make sure all your (or your child's) shots are written on the card. Your child will need this record to enter daycare, kindergarten, school, college, travel and more.

If you have any questions about immunizations, please be sure to ask the nurse.

Signature:(Self) _____ Date: _____

Or (Parent/guardian) _____ Date: _____

R.N.: _____ Date: _____

If vaccine contraindicated, explain: